



Vascular Lab Outpatient Order Form

1	EXAM INFORMATION	EXAM L	OCATIO	N			
M T W TH F Date: Check in Time: Exam Time: STAT (same day) Phone number (required): ASAP (within 1-2 days)		Outp	PeaceHealth St. Joseph M Outpatient Cardiovascu 2980 Squalicum Pa Suite 219 Bellingham, WA 9 Scheduling Phone: 360 Fax 360-543-91		ar Imaging irkway 8225 -788-6068	PeaceHealth Fountain Building Squalicum Parkway PeaceHealth Marble Building Fill Fill Fill Fill Fill Fill Fill Fi	
2 PATIENT INFORMATION – <u>Please Print Clearly</u>							
Name: Phone: Date of Birth:/ Referred by: Clinical Symptoms/History (required; you must have a sign, symptom or known diagnosis. No "Rule Out" or "Follow-up")							
ICD-10*:							
*Indication and ICD-10 are required							
☐ Mesenteric Duplex ☐ Renal Duplex ☐		☐ IVĆ/Iliac ☐ Aorta Ar	☐ Hepatic/Portal☐ IVC/Iliac☐ Aorta Aneurysm Screening☐ Liver/Kidney Transplant			 ABDOMINAL EXAM INSTRUCTIONS: FAST 8 hours prior to exam. NO smoking or chewing gum 4 hours prior to exam. ALL patients should take a.m. medications with a small amount of water. 	
Peripheral Arterial: Lower Extremity ABI (ankle/arm index) Lower Extremity Arterial Duplex Upper Extremity Duplex Hemodialysis Access Graft		BiL	RT	ניםם יו			
Peripheral Venous: ☐ Lower Extremity Venous (DVT) ☐ Lower Extremity (varicose veins/stasis) ☐ Upper Extremity Venous (DVT)) 🔲		000			
Cerebrovascular: ☐ Carotid Duplex							
Other: Vein Mapping Arterial Mapping Other				000			
PLEASE RETURN FORM TO PATIENT AFTER FAXING TO 360-543-9179							
4	Referred by:(Signature)				Date:		

PeaceHealth Medical Group

WR127-011 (08/18/23)

Patient Identification:

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1 of 1

DocType/Description – CORDER (Outpt Orders)